Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4409AGC	A. BUILDING _____ B. WING _____	C 11/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT FRANCIS GROUP HOME CARE 8	**1604 WILDWOOD DRIVE LAS VEGAS, NV 89108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The facility is licensed for eight (8) Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illness, Category I. This Statement of Deficiencies was generated as a result of a self-attestation questionnaire and is not the result of an annual State Licensure survey. Since the facility is in good standing with the bureau and its 2009 annual survey revealed no major regulatory deficiencies, the facility was selected to complete the self-attestation questionnaire in lieu of a 2010 annual survey. The facility completed the questionnaire on 11/23/10. The questionnaire indicated the facility was in regulatory compliance and the facility will receive the grade of A. No further action is necessary. Please retain a copy of this report for your records.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE